BHD-162
(8-77)
Revised (4-97)

State Health Planning and Development Agency

Mailing address: Post Office Box 303025, Montgomery, Alabama 36130-3025
Street address: 100 North Union Street, Suite 870, Montgomery, Alabama 36104

APPLICATION FOR EXTENSION OF CERTIFICATE OF NEED

1. APPLICATION. Application is hereby made for a twelve (12) month extension of the Certificate of Need issued for the health facility described below. (All items must be completed in full before extension of Certificate of Need can be considered.)

2. PROJECT NUMBER	3. CERTIFICATE NUMBER	4. CERTIFICATE EXPIRES

5. LEGAL NAME OF APPLICANT	6. ADDRESS OF APPLICANT
7. NAME OF PROPOSED FACILITY	8. LOCATION OF PROPOSED FACILITY
9. TYPE OF FACILITY	10. ANTICIPATED DATE ON WHICH OBLIGATION IS EXPECTED TO OCCUR AND/OR CONSTRUCTION STARTED

11. ESTIMATED DATE CONSTRUCTION IS SCHEDULED FOR COMPLETION

12. BED CAPACITY

	Gen. Hosp.	Nursing Home SK	Nursing Home ICF	Psychiatric	Other _____
Existing Bed Capacity	_____	_____	_____	_____	_____
Beds provided by New Facility	_____	_____	_____	_____	_____
Addition	_____	_____	_____	_____	_____
Remodeling	_____	_____	_____	_____	_____
Replacement	_____	_____	_____	_____	_____
Capacity Upon Completion	_____	_____	_____	_____	_____

13. ESTIMATED COST OF THE PROJECT	14. PROPOSED FINANCING OF THE PROJECT
Construction $_____ Fixed Equipment $_____ Movable Equipment $_____ Arch. & Eng. $_____ Site Improvements $_____ Financing Charges $_____ Total Cost $_____	Total Estimated Cost $_____ DHEW Loan/Grant $_____ SBA Loan $_____ FHA Mortgage Insurance $_____ Private Financing $_____ Other (Specify) $_____
13a. ATTACH COST ESTIMATE SIGNED BY PROJECT ARCHITECT (Required)	14a. ATTACH STATEMENT FROM FINANCING AGENCY(IES) OF LOAN FEASIBILITY (Required)
15. SITE INFORMATION (Check One) Acquired _____ Option _____ Under Construction _____ Not Acquired _____	16. ARCHITECTURAL PROGRESS Architect Employed _____ Schematic Drawings_____ Working Drawings_____ Advertised for Bids_____

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17. BRIEF DESCRIPTION OF PROPOSED WORK. Include any proposed deletion, new or substantial change in the scope of the project as described in the Program Narrative submitted in support of the original Application.

18. BUDGET AND UTILIZATION DATA. If there has been a material change in the estimated cost of the construction and/or operation of the facility (or if data were not submitted with the original application) it will be necessary to complete PART FIVE of the original application form.
Part Five attached: _____ Yes _____ No

19. COST CONTAINMENT. Attach Cost Containment Statement showing how the project will foster cost containment through improved efficiency and productivity, including promotion of cost-effective factors such as ambulatory care, preventive health care services, home health care, sharing of services with other facilities, and design and construction economies.

20. In submitting this Application, the Applicant:
Understands that extension of the Certificate will depend upon compliance with minimum criteria.
A. Needs of the Area as set forth in the up-dated Alabama State Health Plan.
B. 1. Site Procurement: Must have acquired or holds option to purchase. Site must be inspected and approved.
2. Architectural Progress: Must have approved working drawings.
3. Financial Status: Must present evidence that appropriate and necessary financing is final and immediately available.
4. Program Narrative: Must be updated to show change in scope of service.
5. Budget and Utilization Data: Must be on file and up-to-date. Maximum increase in costs and charges must be within Cost of Living Council guidelines.
6. Cost Containment: Satisfactory statement must be on file.
C. Understands that the Certificate if issued, will expire not more than twelve (12) months from date of issuance and will not be subject to further extension.
D. Agrees to notify Health Development, State Health Planning and Development Agency, if and when the project is abandoned or is placed under contract.
E. The Certificate of Need, if issued, is not transferrable and any action on the part of the Applicant to transfer or assign the Certificate of Need will render the Certificate of Need null and void.

21. SIGNATURE OF RESPONSIBLE OFFICER	22. TITLE OF OFFICER
_____	_____
23. NAME OF RESPONSIBLE OFFICER	24. DATE
_____	_____

Attachments:
_____ Cost Estimate
_____ Statement from Financing Agency
_____ Part Five Budget and Utilization Data
_____ Cost Containment Statement

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SUPPLEMENT TO APPLICATION: BUDGET AND UTILIZATION

1. NAME OF APPLICANT	2. NAME OF FACILITY
3. TYPE OF FACILITY	4. LOCATION OF FACILITY

5. HISTORICAL DATA: Give information for last three (3) years for which complete data are available

A. OCCUPANCY DATA

1. ACCOMMODATION	NUMBER OF BEDS			ADMISSIONS OR DISCHARGES			TOTAL PATIENT DAYS			% OCCUPANCY		
	YR	YR	YR	YR	YR	YR	YR	YR	YR	YR	YR	YR
PRIVATE												
SEMI-PRIVATE												
WARD												
TOTALS												

2. CLINICAL SERVICES	NUMBER OF BEDS			ADMISSIONS OR DISCHARGES			TOTAL PATIENT DAYS			% OCCUPANCY		
	YR	YR	YR	YR	YR	YR	YR	YR	YR	YR	YR	YR
MEDICINE AND SURGERY												
OBSTETRICS												
PEDIATRICS												
PSYCHIATRY												
OTHER												
TOTALS												

PERCENT OF GROSS REVENUE

B. SOURCE OF PAYMENT

	YR _____	YR _____	YR _____
BLUE CROSS			
OTHER INSURANCE			
MEDICARE			
MEDICAID			
SELF-PAY			
FREE CARE			
OTHER			
SUBTOTAL			
BAD DEBTS	%	%	%
TOTALS	100%	100%	100%

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BUDGET AND UTILIZATION DATA

5. HISTORICAL DATA (Cont'd)

2. NAME OF FACILITY _____

C. Statement of Income and Expense (Give information for last three years for which complete data are available.)	20 _____ Total	20 _____ Total	20 _____ Total	20 _____ Per Diem
Revenue from Services to Patients Inpatient Services Routine (Nursing Service Areas)				
Other				
Outpatient Services				
Emergency Services				
Other Operating Revenue Recoveries				
Other				
Gross Operating Revenue				
Deductions from Operating Revenue Contract Adjustments				
Discounts/Misc. Allowances				
Provision for Charity Services				
Provision for Uncollectibles				
Total Deductions				
Net Operating Revenue				
Operating Expenses Salaries and Wages				
Physician's Salaries and Fees				
Supplies				
Depreciation				
Interest (Other than Mortgage)				
Other Expenses				
Total Operating Expenses				
Capital Expenditure Retirement of Principal				
Interest				
Total Capital Expenditure				
Total Expenses (Operating and Capital)				
Operating Income (Loss)				
Other Revenue (Expense) - Net				
Net Income (Loss)				

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SUPPLEMENT TO APPLICATION: BUDGET AND UTILIZATION DATA

1. NAME OF APPLICANT	2. NAME OF FACILITY
3. TYPE OF FACILITY	4. LOCATION OF FACILITY

6. PROJECTED DATA : Give information projected to cover the first two (2) years of operation after completion of project.

A. OCCUPANCY DATA

1. ACCOMMO-DATION	NUMBER OF BEDS		ADMISSIONS OR DISCHARGES		TOTAL PATIENT DAYS		% OCCUPANCY	
	1st YEAR	2nd YEAR	1st YEAR	2nd YEAR	1st YEAR	2nd YEAR	1st YEAR	2nd YEAR
PRIVATE								
SEMI-PRIVATE								
WARD								
TOTALS								

2. CLINICAL SERVICES	NUMBER OF BEDS		ADMISSIONS OR DISCHARGES		TOTAL PATIENT DAYS		% OCCUPANCY	
	1st YEAR	2nd YEAR	1st YEAR	2nd YEAR	1ST YEAR	2ND YEAR	1ST YEAR	2ND YEAR
MEDICINE AND SURGERY								
OBSTETRICS								
PEDIATRICS								
PSYCHIATRY								
OTHER								
TOTALS								

B. SOURCE OF PAYMENT	PERCENT OF GROSS REVENUE YR _____	YR _____
BLUE CROSS		
OTHER INSURANCE		
MEDICARE		
MEDICAID		
SELF-PAY		
FREE CARE		
OTHER		
SUBTOTAL	%	%
BAD DEBTS		
TOTAL	100%	100%

NOTE: Include both inpatient and outpatient data.

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BUDGET AND UTILIZATION

NAME OF FACILITY _____

6. Projected Data (Cont'd)

C. Statement of Projected Income and Expenses (First two (2) years after completion of project.)	20____		20____	
	Total	Per Diem	Total	Per Diem
Revenue from Services to Patients Inpatient Services Routine (Nursing Service Areas)				
Other				
Outpatient Services				
Emergency Services				
Other Operating Revenue Recoveries				
Other				
Gross Operating Revenue				
Deductions from Operating Revenue Contract Adjustments				
Discount/Misc. Allowances				
Provision for Charity Services				
Provision for Uncollectibles				
Total Deductions				
Net Operating Revenue				
Operating Expenses Salaries and Wages				
Physician's Salaries and Fees				
Supplies				
Depreciation				
Interest (Other than Mortgage)				
Other Expenses				
Total Operating Expenses				
Capital Expenditure Incurred Prior to this Project - Retirement of Principal				
- Interest				
This Project - Retirement of Principal				
- Interest				
Total Capital Expenditure				
Total Expenses (Operating & Capital)				
Operating Income (Loss)				
Other Revenue (Expense) – Net				

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BUDGET AND UTILIZATION

7. INFORMATION REGARDING PROPOSED FINANCING

Total amount to be borrowed $_____

Anticipated interest rate _____%

Term of loan _____ years

Method of calculating interest and principal payments:

8. ATTACHMENTS

(1) Schedule of current charges.

(2) Schedule of proposed charges after completion of this project.

(3) State of existing capital indebtedness.

(4) Schedule showing projected annual depreciation for buildings, fixed equipment, and movable equipment.